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HMSC Andrew Harris
Southwark Coroners Court
1 Tennis Street
London
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April 5, 2020

Dear Mr Harris

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Re: Mr Adrian Ashford

I am writing in response to your report dated 7th February 2020 and referenced above. The report raised two matters of concern

The matter raised are:

1. Dr [redacted], GP and [redacted], Divisional Medical Director, both gave evidence of the value of having some system for regular weighing and that it might save lives.. This would enable reported weight loss to be verified and quantified and highlight triggers for investigation in a timely manner. But there appears to be no systematic process of recording weights.

2. The consultant in acute medicine who was on call when Mr Ashford was admitted to A&E on 12th December 2018 by psychiatrists, concerned about the risk of GI bleeding, diagnosed constipation and returned him to a psychiatric bed. It appears he failed to identify the risks of GI bleed identified in A&E on 11th, nor the reasons for concern for urgent transfer (dehydration and drop in haemoglobin from 126 to 102g/l). On 14th he also failed to consider referral to a gastro-enterologist, after his blood pressure fell to 83/59 with a tachycardia of 112. He told the court "he was not thinking GI bleed". Asked about learning from this death, he said that there was no change in his practice, other than increased awareness.

<u>In response to the first matter:</u>

Whether there is benefit in a systematic process of recording patients' weights-

In accordance with your recommendation, the Trust agrees that there is a benefit in a systematic process of recording patients' weight".

To this effect:

- The Trust has now implemented a trust-wide electronic patient record system (since May-June 2019). The system enables weight to be consistently recorded electronically which can then be observed by all staff within the Trust

- The Trust also has a systematic process in place that covers weekly weights. On admission, there is a nursing task called safety assessment. The safety assessment is a set of assessments bundled into one task. One of the assessments within the safety assessment is the Nutritional Assessment, which includes patient weight/ height/ BMI. This task is then presented automatically on a weekly basis following admission. Weights and heights are then viewable in iView for all staff within the Trust

- Additionally, the electronic medicines management system has recently implemented a new way in which to get weights onto the system. There is now an order on the system that can be ordered to any desired frequency. This needs to be completed from the drug chart. Once completed in the drug chart the weights are viewable in iView as well.

<u>In response to the second matter:</u>

Whether the consultant involved in this case would benefit from reporting this case to whoever conducts his appraisal to consider if he would benefit from further support or professional development-

I have met with the consultant involved and we have discussed this case fully. The consultant has conducted a complete case review and reflection that he will use in his annual appraisal. He has changed his own clinical practice and has also made his colleagues aware through a grand round to share the learning. A new standard operating procedure for managing suspected upper GI bleeding has been produced and circulated.

I wish to assure you that my team and I take these concerns very seriously and remain open to any suggestions about how we could further improve current processes.

Should you have any questions in regard to any of the information in this letter or require any further information please do not hesitate to contact me.

Yours sincerely

Dr Elizabeth Aitken
Medical Director
Lewisham and Greenwich NHS Trust